

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035261</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Rosewood Care Center of Alton</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2001</u> to <u>6/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>3490 Humbert Road</u> <u>Alton</u> <u>62002</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Madison</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(618) 465-2626</u> Fax # () _____		Paid Preparer (Signed) <u>Accountant's Compilation Report Attached</u> _____ (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> <u>233 East Center Drive, Alton, IL 62002</u> (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>																									
IDPA ID Number: <u>431446787001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>5/15/89</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																											

SEE ACCOUNTANT'S COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center of Alton# 0035261 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>180</u>	Skilled (SNF)	<u>180</u>	<u>65,700</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,700</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>7,670</u>	<u>7,670</u>	8
9	SNF/PED					9
10	ICF	<u>6,708</u>	<u>34,485</u>		<u>41,193</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,708</u>	<u>34,485</u>	<u>7,670</u>	<u>48,863</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.37%

D. How many bed-hold days during this year were paid by Public Aid?

15 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 5/15/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 5/15/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 42 and days of care provided 7,670Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/02 Fiscal Year: 6/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Rosewood Care Center of Alton

0035261

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	252,986	27,345	8,798	289,129		289,129		289,129			1
2	Food Purchase		231,263		231,263		231,263	(7,458)	223,805			2
3	Housekeeping	176,591	33,712		210,303		210,303		210,303			3
4	Laundry	67,911	19,446		87,357		87,357		87,357			4
5	Heat and Other Utilities			125,731	125,731		125,731	533	126,264			5
6	Maintenance	29,236	16,071	59,330	104,637		104,637	22,686	127,323			6
7	Other (specify):* Sanitation			15,088	15,088		15,088		15,088			7
8	TOTAL General Services	526,724	327,837	208,947	1,063,508		1,063,508	15,761	1,079,269			8
	B. Health Care and Programs											
9	Medical Director			5,625	5,625		5,625		5,625			9
10	Nursing and Medical Records	2,333,842	227,820	76,688	2,638,350		2,638,350		2,638,350			10
10a	Therapy	72,996	1,705	348,008	422,709		422,709	7,076	429,785			10a
11	Activities	58,308	5,494	1,551	65,353		65,353		65,353			11
12	Social Services	62,821	10	1,551	64,382		64,382		64,382			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,527,967	235,029	433,423	3,196,419		3,196,419	7,076	3,203,495			16
	C. General Administration											
17	Administrative			1,209,101	1,209,101		1,209,101	(1,021,957)	187,144			17
18	Directors Fees											18
19	Professional Services			8,136	8,136		8,136	47,083	55,219			19
20	Dues, Fees, Subscriptions & Promotions			27,075	27,075		27,075	(8,294)	18,781			20
21	Clerical & General Office Expenses	139,465	36,387	21,013	196,865		196,865	226,018	422,883			21
22	Employee Benefits & Payroll Taxes			372,930	372,930		372,930	39,626	412,556			22
23	Inservice Training & Education											23
24	Travel and Seminar			708	708		708	(25)	683			24
25	Other Admin. Staff Transportation			13,685	13,685		13,685	22,611	36,296			25
26	Insurance-Prop.Liab.Malpractice			53,562	53,562		53,562	8,275	61,837			26
27	Other (specify):*											27
28	TOTAL General Administration	139,465	36,387	1,706,210	1,882,062		1,882,062	(686,663)	1,195,399			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,194,156	599,253	2,348,580	6,141,989		6,141,989	(663,826)	5,478,163			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center of Alton

#0035261

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					7,322	7,322	289,374	296,696			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							871,988	871,988			32
33	Real Estate Taxes			140,022	140,022		140,022		140,022			33
34	Rent-Facility & Grounds			1,888,636	1,888,636		1,888,636	(1,871,831)	16,805			34
35	Rent-Equipment & Vehicles			4,484	4,484		4,484		4,484			35
36	Other (specify):*			7,322	7,322	(7,322)						36
37	TOTAL Ownership			2,040,464	2,040,464		2,040,464	(710,469)	1,329,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		189,988	21,182	211,170		211,170	(1,282)	209,888			39
40	Barber and Beauty Shops			5,144	5,144		5,144		5,144			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		189,988	124,876	314,864		314,864	(1,282)	313,582			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,194,156	789,241	4,513,920	8,497,317		8,497,317	(1,375,577)	7,121,740			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Rosewood Care Center of Alton

0035261

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,650)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(6,189)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,282)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(808)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(25)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,277)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,786)	20		28
29	Other-Attach Schedule Marketing Salary	(56,854)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (80,871)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(1,294,706)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,294,706)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,375,577)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Rosewood Care Center of Alton

ID# 0035261

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salary	\$ (56,854)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(56,854)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Alton

0035261

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,458)	0	0	0	0	0	0	0	0	0	0	(7,458)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	533	0	0	0	0	0	0	0	0	533	5
6	Maintenance	0	0	22,686	0	0	0	0	0	0	0	0	22,686	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,458)	0	23,219	0	0	0	0	0	0	0	0	15,761	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	7,076	0	0	0	0	0	0	0	0	0	7,076	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	7,076	0	0	0	0	0	0	0	0	0	7,076	16
	C. General Administration													
17	Administrative	0	(1,209,101)	187,144	0	0	0	0	0	0	0	0	(1,021,957)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	47,083	0	0	0	0	0	0	0	0	47,083	19
20	Fees, Subscriptions & Promotions	(9,063)	0	769	0	0	0	0	0	0	0	0	(8,294)	20
21	Clerical & General Office Expenses	(56,854)	0	282,872	0	0	0	0	0	0	0	0	226,018	21
22	Employee Benefits & Payroll Taxes	0	0	39,626	0	0	0	0	0	0	0	0	39,626	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(25)	0	0	0	0	0	0	0	0	0	0	(25)	24
25	Other Admin. Staff Transportation	0	0	22,611	0	0	0	0	0	0	0	0	22,611	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,275	0	0	0	0	0	0	0	0	8,275	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(65,942)	(1,209,101)	588,380	0	0	0	0	0	0	0	0	(686,663)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,400)	(1,202,025)	611,599	0	0	0	0	0	0	0	0	(663,826)	29

Summary B

6/30/2002

[illegible]

Facility Name & ID Number Rosewood Care Center of Alton# 0035261

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Management Fee	\$ 1,209,101	HSM Management Services, Inc.	100.00%	\$	\$ (1,209,101)
2	V						
3	V	10a Therapy	348,008	Rosewood Therapy Services, Inc.	0.00%	355,084	7,076
4	V						
5	V	34 Rent	1,888,636	Alton Real Estate, Inc.	0.00%		(1,888,636)
6	V	30 Depreciation		Alton Real Estate, Inc.		259,208	259,208
7	V	32 Interest		Alton Real Estate, Inc.		875,427	875,427
8	V	32 Amortization - Loan Fee		Alton Real Estate, Inc.		2,750	2,750
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 3,445,745			\$ 1,492,469	\$ * (1,953,276)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton# 0035261Report Period Beginning: 7/1/2001Ending: 6/30/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 533	\$ 533
16	V	17 See Schedule VIII		HSM Management Services, Inc.	100.00%	187,144	187,144
17	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	282,872	282,872
18	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	39,626	39,626
19	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	22,611	22,611
20	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	30,166	30,166
21	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	16,805	16,805
22	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	47,083	47,083
23	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	8,275	8,275
24	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	22,686	22,686
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	769	769
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 658,570	\$ * 658,570

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Rosewood Care Center of Alton # 0035261 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	0.75	805,936	3.23	8.06	Salary	\$ 70,644	17-8	1
2	Darrell Hoefling	Vice-President	Management	0.25	574,400	3.23	8.06	Salary	50,348	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 120,992		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton# 0035261

Report Period Beginning:

7/1/2001Ending: 7/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Hsm Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	78,691,907	17	\$ 1,501,328	\$ 6,341,792	\$ 120,992	1
2	21	Salaries - Others	Total Cost	78,691,907	17	2,971,209	6,341,792	239,450	2
3	22	Payroll Taxes	Total Cost	78,691,907	17	275,345	6,341,792	22,190	3
4	22	Employee Benefits	Total Cost	78,691,907	17	147,178	6,341,792	11,861	4
5	25	Travel	Total Cost	78,691,907	17	280,565	6,341,792	22,611	5
6	30	Depreciation	Total Cost	78,691,907	17	359,545	6,341,792	28,976	6
7	34	Building Rent	Total Cost	78,691,907	17	208,527	6,341,792	16,805	7
8	19	Professional Services	Total Cost	78,691,907	17	584,225	6,341,792	47,083	8
9	21	Telephone	Total Cost	78,691,907	17	234,306	6,341,792	18,883	9
10	26	Insurance	Total Cost	78,691,907	17	102,679	6,341,792	8,275	10
11	21	Taxes, Licenses & Office Sup.	Total Cost	78,691,907	17	304,491	6,341,792	24,539	11
12	6	Maintenance	Total Cost	78,691,907	17	276,408	6,341,792	22,276	12
13	5	Heat & Other Utilities	Total Cost	78,691,907	17	6,619	6,341,792	533	13
14	20	Dues & Subscriptions	Total Cost	78,691,907	17	9,548	6,341,792	769	14
15	17	Direct - Admin	Direct Cost	1	1	66,152	1	66,152	15
16	17	Direct - Admin	Direct Cost	16	16	922,567	0	0	16
17	22	Direct - Payroll Taxes	Direct Cost	1	1	5,575	1	5,575	17
18	22	Direct - Payroll Taxes	Direct Cost	16	16	73,441	0	0	18
19	30	Direct - Depreciation	Direct Cost	1	1	1,190	1	1,190	19
20	30	Direct - Depreciation	Direct Cost	16	16	15,119	0	0	20
21	25	Direct - Travel	Direct Cost	1	1	0	1	0	21
22	25	Direct - Travel	Direct Cost	16	16	15,827	0	0	22
23	6	Maintenance	Direct Cost	1	1	410	1	410	23
24	6	Maintenance	Direct Cost	16	16	2,816	0	0	24
25	TOTALS					\$ 8,365,070	\$ 5,461,256	\$ 658,570	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Bank of America		X	Refinance Mortgage	\$35,233.00	10/26/99	\$ 4,027,366	\$	11/2009	8.89%	\$ 460,257	1	
2	Firststar Bank		X	Mortgage-60 Bed Addition	Varies	01/20/97	3,086,000		11/30/01	Prm + 1/4	312,886	2	
3	Bank of America		X	Refinance Mortgage	\$98,793.97	6/1/02	16,150,000	16,140,166	6/2035	6.61%	146,002	3	
4	Less: Related Party Interest Income Offset										(43,718)	4	
5	Interest Income										(6,189)	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$134,026.97		\$ 23,263,366	\$ 16,140,166				\$ 869,238	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13							Amortization of Loan Costs				2,750	13	
14	TOTAL Non-Facility Related						\$	\$				\$ 2,750	14
15	TOTALS (line 9+line14)						\$ 23,263,366	\$ 16,140,166				\$ 871,988	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,870 Line # 32

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

						<i>Important</i> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	116,000	1																							
1. Real Estate Tax accrual used on 2001 report.								\$																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)								\$	50,262	2																							
3. Under or (over) accrual (line 2 minus line 1).								\$	(65,738)	3																							
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)								\$	205,760	4																							
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)								\$		5																							
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.																																	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)								\$		6																							
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.								\$	140,022	7																							
Real Estate Tax History:																																	
Real Estate Tax Bill for Calendar Year:		1997	74,880	8	<table border="1"> <thead> <tr> <th colspan="3">FOR OHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001</td> <td>\$</td> <td></td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td></td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td></td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td></td> <td>16</td> </tr> </tbody> </table>						FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2001	\$		13	14	PLUS APPEAL COST FROM LINE 5	\$		14	15	LESS REFUND FROM LINE 6	\$		15	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16
FOR OHF USE ONLY																																	
13	FROM R. E. TAX STATEMENT FOR 2001	\$		13																													
14	PLUS APPEAL COST FROM LINE 5	\$		14																													
15	LESS REFUND FROM LINE 6	\$		15																													
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16																													
	1998	97,312	9																														
	1999	97,506	10																														
	2000	100,525	11																														
	2001	136,260	12																														
2000 taxes paid - \$50,262																																	
Accrual = 2001 tax bill (136,260) + 1/2 of estimated 2002 taxes (69,500)																																	

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0035261

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>23-2-02-31-00-000-049</u>	<u>Pebble Creek Lot B</u>	\$ <u>132,657.66</u>	\$ <u>132,657.66</u>
2. <u>23-2-02-31-00-000-048</u>	<u>Pebble Creek Lot D</u>	\$ <u>3,602.38</u>	\$ <u>3,602.38</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>136,260.04</u></u>	\$ <u><u>136,260.04</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

39,200

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	58,679	1988	\$ 278,953	1
2	60 Bed Addition	19,479	1988	25,461	2
3	TOTALS	78,158		\$ 304,414	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton

0035261

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	\$ 3,401,372	\$	10-25	\$ 145,309	\$ 145,309	\$ 2,036,644	4
5	60			1997	2,341,080		25	93,643	93,643	374,572	5
6											6
7											7
8											8
	Improvement Type**										
9	Heating and A/C Modification			1990	2,786		20	139	139	1,726	9
10	Lawn Sprinkler			1992	14,401		25	576	576	5,616	10
11	General Site Work			1992	27,500		25	1,100	1,100	10,725	11
12	Fence			1990	3,627		25	145	145	1,595	12
13	Walk-in Cooler			1989	5,438		10			5,438	13
14	Sinks			1989	3,528		10			3,528	14
15	Exhaust Hood			1989	4,609		10			4,609	15
16	Fire System			1989	1,198		10			1,198	16
17	Sign			1989	5,178		10			5,178	17
18	Telephone System			1989	7,836		10			7,836	18
19	Cubicle Curtain Track			1989	8,673		10			8,673	19
20	10 Baseboard Heaters			1989	2,106		10			2,106	20
21	Heat Pump			1990	2,786		10			2,651	21
22	Service Door			1991	3,150		10	105	105	3,150	22
23	Generator			1989	14,857		10			14,857	23
24	Carpet			1989	9,170		10			9,170	24
25											25
26											26
27	Leasehold Improvements - Facility										27
28	Painting			1994	2,058	45	7	45		2,058	28
29	Tiling/Painting			1995	2,044	228	7	228		2,044	29
30	Nurse Station Improvements			1995	1,868	267	7	267		1,758	30
31	Painting			1995	475	68	7	68		448	31
32	Carpeting			1996	14,400	2,057	7	2,057		13,199	32
33	Base Stripping			1996	1,096	157	7	157		981	33
34	Wallpapering			1996	2,696	385	7	385		2,406	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	<u>Carpeting</u>	<u>1996</u>	\$ <u>636</u>	\$ <u>91</u>	<u>7</u>	\$ <u>91</u>		\$ <u>531</u>		37
38	<u>Wallcovering</u>	<u>1996</u>	<u>9,813</u>	<u>1,402</u>	<u>7</u>	<u>1,402</u>		<u>8,062</u>		38
39	<u>Painting</u>	<u>1996</u>	<u>2,700</u>	<u>386</u>	<u>7</u>	<u>386</u>		<u>2,215</u>		39
40	<u>Draperies</u>	<u>1997</u>	<u>5,190</u>	<u>741</u>	<u>7</u>	<u>741</u>		<u>3,520</u>		40
41	<u>Painting</u>	<u>1997</u>	<u>4,892</u>	<u>699</u>	<u>7</u>	<u>699</u>		<u>3,225</u>		41
42	<u>Wallpaper</u>	<u>1998</u>	<u>1,329</u>	<u>190</u>	<u>7</u>	<u>190</u>		<u>823</u>		42
43	<u>Tech Electronics</u>	<u>1998</u>	<u>2,735</u>	<u>33</u>	<u>7</u>	<u>33</u>		<u>1,206</u>		43
44	<u>Computer Cabling</u>	<u>2000</u>	<u>3,380</u>	<u>483</u>	<u>7</u>	<u>483</u>		<u>765</u>		44
45										45
46										46
47										47
48	<u>Leasehold Improvements - Management Company:</u>									48
49	<u>Office Construction/Improvements</u>	<u>1995</u>	<u>617</u>		<u>5</u>			<u>617</u>		49
50	<u>Office Design</u>	<u>1995</u>	<u>56</u>		<u>5</u>			<u>56</u>		50
51	<u>Office Shelving</u>	<u>1996</u>	<u>132</u>		<u>4</u>			<u>132</u>		51
52	<u>Office Expansion</u>	<u>1996</u>	<u>582</u>		<u>4</u>			<u>582</u>		52
53	<u>Office Expansion</u>	<u>1997</u>	<u>1,559</u>		<u>3</u>			<u>1,559</u>		53
54	<u>Office Expansion</u>	<u>1998</u>	<u>880</u>		<u>3</u>	<u>65</u>	<u>65</u>	<u>880</u>		54
55	<u>Office Addition</u>	<u>1999</u>	<u>435</u>		<u>3</u>	<u>145</u>	<u>145</u>	<u>435</u>		55
56	<u>Door Locks</u>	<u>1999</u>	<u>217</u>		<u>3</u>	<u>72</u>	<u>72</u>	<u>187</u>		56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 5,919,085	\$ 7,232		\$ 248,531	\$ 241,299	\$ 2,546,961		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 392,352	\$	\$ 36,190	\$ 36,190	5-7 Yrs	\$ 82,916	71
72	Current Year Purchases	24,320		2,257	2,257	5-7 Yrs	2,257	72
73	Fully Depreciated Assets	481,930					481,930	73
74								74
75	TOTALS	\$ 898,602	\$	\$ 38,447	\$ 38,447		\$ 567,103	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 39,632	\$	\$ 9,718	\$ 9,718	5 Yrs	\$ 26,597	76
77										77
78										78
79										79
80	TOTALS			\$ 39,632	\$	\$ 9,718	\$ 9,718		\$ 26,597	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,161,733	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 7,232	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 296,696	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 289,464	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,140,661	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

If NO, see instructions.

☐ YES ☐ NO**SEE ACCOUNTANTS' COMPILATION REPORT**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	10,828	\$ 178,500	\$	10,828	\$ 178,500	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		748	17,587		748	17,587	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		19,358	158,997	1,705	19,358	160,702	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				172,988		172,988	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, Enterals, Other (specify): I.V. Therapy & X-Ray	39-8					36,900		36,900	13
14	TOTAL			\$	30,934	\$ 355,084	\$ 211,593	30,934	\$ 566,677	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 529,412	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	700,315		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	49,150		7
8	Accounts Receivable (owners or related parties)	(69)		8
9	Other(specify):	4,133		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,282,941	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	58,334		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(43,331)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,003	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,297,944	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 484,871	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,837		30
31	Accrued Taxes Payable (excluding real estate taxes)	86,735		31
32	Accrued Real Estate Taxes(Sch.IX-B)	205,760		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,049,203	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,049,203	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 248,741	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,297,944	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 238,454	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 238,454	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	210,687	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(200,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,287	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 248,741	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,929,161	1
2	Discounts and Allowances for all Levels	(1,610,585)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,318,576	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,488,827	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,488,827	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,209	13
14	Non-Patient Meals	6,650	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,859	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,852	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,852	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	955	28
28a	Lab Discounts	1,282	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,237	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,840,351	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,063,508	31
32	Health Care	3,196,419	32
33	General Administration	1,882,062	33
	B. Capital Expense		
34	Ownership	2,040,464	34
	C. Ancillary Expense		
35	Special Cost Centers	216,314	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,497,317	40
41	Income before Income Taxes (line 30 minus line 40)**	343,034	41
42	Income Taxes	(132,347)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 210,687	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center of Alton# 0035261Report Period Beginning: 7/1/2001Ending: 6/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,082	2,206	\$ 58,525	\$ 26.53	1
2	Assistant Director of Nursing	2,255	2,390	51,957	21.74	2
3	Registered Nurses	25,415	26,937	502,379	18.65	3
4	Licensed Practical Nurses	29,893	31,683	499,102	15.75	4
5	Nurse Aides & Orderlies	116,034	122,984	1,150,995	9.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,061	6,424	72,996	11.36	8
9	Activity Director					9
10	Activity Assistants	6,090	6,455	58,308	9.03	10
11	Social Service Workers	5,748	6,092	62,821	10.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,095	29,778	252,986	8.50	15
16	Dishwashers					16
17	Maintenance Workers	2,136	2,264	29,236	12.91	17
18	Housekeepers	23,265	24,659	176,591	7.16	18
19	Laundry	8,893	9,426	67,911	7.20	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,070	12,793	139,465	10.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,802	6,149	70,884	11.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	273,839	290,240	\$ 3,194,156 *	\$ 11.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	385	\$ 8,798	1-3	35
36	Medical Director	Contract	5,625	9-3	36
37	Medical Records Consultant	70	1,420	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	1,551	11-3	44
45	Social Service Consultant	60	1,551	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	575	\$ 18,945		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	80	\$ 2,987	10-3	50
51	Licensed Practical Nurses	2,244	71,526	10-3	51
52	Nurse Aides	50	755	10-3	52
53	TOTAL (lines 50 - 52)	2,374	\$ 75,268		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Alton

STATE OF ILLINOIS

0035261

Report Period Beginning:

7/1/2001

Ending:

Page 23

6/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 94,344 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 98,550
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,650
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: C.J. Schlosser & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not finished
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER INC. OF ALTON
RECLASSIFICATIONS
06/30/02

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
OTHER	36	(7,322)
DEPRECIATION	30	7,322
TO RECLASS DEPRECIATION EXPENSE DUE TO PROTECTED CELL		